CHAPTER 35
ACCIDENT AND HEALTH INSURANCE
BLANKET ACCIDENT AND SICKNESS INSURANCE
[Prior to 10/22/86, Insurance Department[510]]

191—35.1(509) Purpose. The purpose of this regulation is to establish guidelines for insurers to make special risk coverage available to particular groups that will be exposed to specific hazards for a certain period of time.

191—35.2(509) Scope. These rules shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapters 508 and 515.

191—35.3(509) Definitions.

35.3(1) Blanket accident and sickness insurance is hereby declared to be that form of accident, sickness or accident and sickness insurance designed to insure against specified hazards incident to or defined by reference to a particular activity or activities and covering groups of persons as enumerated in the following subparagraphs:

a. Under a policy issued to an employer, who shall be deemed the policyholder covering any group of employees defined by reference to specific hazards incident to an activity or activities of the policyholder.

b. Under a policy issued to a college, high school, junior high school, grade school, school district, school jurisdictional unit or other institution of learning; or to the head, principal, governing board of any such educational unit who or which shall be deemed the policyholder covering students, teachers or employees.

c. Under a policy issued to any religious, charitable or educational organization, or branch thereof, which shall be deemed the policyholder covering any group of members or participants defined by reference to specified hazards incident to an activity or activities sponsored or supervised by such policyholder.

d. Under a policy issued to a sports team, youth camp, recreational organization or sponsor thereof, which shall be deemed the policyholder, covering members, campers, participants, employees, officials or supervisors.

e. Under a policy issued to any volunteer fire department, first aid, civil defense or other such volunteer organizations, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

f. Under a policy issued to a newspaper or other publisher, which shall be deemed the policyholder, covering its carriers.

g. Under a policy issued to an association, other than a labor union, trade association or industrial association, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

h. Under a policy issued to cover any other risk or class of risks which, in the discretion of the commissioner, may be properly eligible for blanket accident and sickness insurance. The discretion of the commissioner may be exercised on an individual risk basis or class of risks, or both.

35.3(2) Brochure shall mean an instrument, booklet or pamphlet setting forth a statement as to the insurance protection provided, to whom the insurance benefits are payable, sufficient information on the procedure an insured shall follow in filing a claim and such other provisions as are in the opinion of the commissioner of insurance necessary to inform the holder thereof as to rights under the policy.

35.3(3) For purposes of 2005 Iowa Acts, House File 420, section 1, relating to biologically based mental illness coverage in a group policy, contract or plan providing for third-party payment of health, medical, and surgical coverage benefits issued by a carrier or by an organized delivery system, "biologically based mental illness" shall mean the following mental disorders as they are defined under the following diagnostic classes within the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, edition DSM-IV-TR:

a. Schizophrenia. Diagnostic codes 295.xx and 293.xx, including all specific subtypes of schizophrenia listed under those two diagnostic codes and using an appropriate extension. Schizophrenia also includes diagnostic codes 295.40, 295.70, 297.1, 298.8, 297.3 and 298.9.

b. Bipolar disorders. Diagnostic code 296.xx including all specific subtypes of bipolar disorders listed under that diagnostic code and using an appropriate extension. Bipolar disorders also includes diagnostic codes 286.89, 301.13, 296.80, 293.83 and 296.90.

c. Major depressive disorders. Diagnostic codes 296.2x and 296.3x including all specific subtypes of major depressive disorders listed under those two diagnostic codes and using an appropriate extension.

d. Schizo-affective disorders. Diagnostic code 295.70.

e. Obsessive-compulsive disorders. Diagnostic code 300.3.

f. Pervasive development disorders. Diagnostic codes 299.00, 299.80 and 299.10.

g. Autistic disorders. Diagnostic code 299.00.

191—35.4(509) Required provisions. No blanket policy as herein defined shall be issued or delivered in this state unless a copy of the policy and brochure if required, has been approved by the commissioner of insurance in accordance with the provisions set forth in rule 35.7(509). All policies of blanket accident or sickness insurance or combination thereof issued in this state shall contain in substance the following provisions:

35.4(1) A provision that the policy including endorsements and a copy of the application, if any, of the policyholder and the persons insured shall constitute the entire contract between the parties, and that any statement made by the policyholder or by a person insured shall in the absence of fraud, be deemed a representation and not a warranty. No such statement shall be used in defense of a claim under the policy, unless it is contained in a written application. If a copy of such application is not delivered to the person insured the insurer shall be precluded from introducing such application as evidence in any action involving any statements contained therein.

35.4(2) A provision that written notice of sickness or of injury must be given to the insurer within 20 days of the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

35.4(3) A provision that the insurer will furnish either to the claimant or to the policyholder for delivery to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after giving such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

35.4(4) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within 90 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

35.4(5) A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of due written proof of such loss, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

35.4(6) A provision that the insurer at its own expense, shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy where it is not prohibited by law.

35.4(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

191—35.5(509) Application and certificates not required. An individual application need not be required from a person covered under a blanket accident and sickness policy, nor shall it be necessary for the insurer to furnish each person a certificate; however, a brochure as herein defined shall be issued to the policyholder for delivery to each person insured as defined in 35.3(1)*"b"* and *"g."*

191—35.6(509) Facility of payment. All benefits under any blanket accident and sickness policy shall be payable to the person insured, to a designated beneficiary or beneficiaries, or to their estate, except that if the person insured be a minor or otherwise not competent to give a valid release, such benefits may be made payable to their parent, guardian or other person actually supporting the insured, designated beneficiary, or beneficiaries. The policy may also provide that all or a portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may with the consent of the insured be paid directly to the hospital or person rendering such services, but the policy may not require that the services be rendered by a particular hospital or person. Payment so made shall discharge the obligation of the insurer with respect to the amount of insurance so paid.

These rules are intended to implement Iowa Code section 509.6.

191—35.7(509) General filing requirements.

35.7(1) All filings submitted to the Iowa division of insurance must be accompanied by a prepaid self-addressed envelope large enough to contain the complete submission.

35.7(2) All filings must be accompanied by the most recent edition of the applicable National Association of Insurance Commissioners (NAIC) Transmittal Document (form "LH TD-1") and Filing Attachment(s) (form "LH FFA-1, Rates" or form "LH RFA-A" or both) in duplicate, and a brief description of the purpose for the filing must be provided on the transmittal document. If the filing amends or changes a prior filing, the previous provisions and new provisions should be described in the applicable space on the forms with an explanation for the changes. Detailed instructions are posted on the division's Web site: www.iid.state.ia.us.

35.7(3) A copy of each form for which approval is requested shall be transmitted with the filing. If the forms submitted refer to both life and accident and health coverages, the Transmittal Document and Filing Attachment(s) must be submitted in triplicate with two copies of each form for which approval is requested. Detailed instructions are posted on the division's Web site: www.iid.state.ia.us.

35.7(4) Each filing must be submitted to the division of insurance not less than 60 days prior to the effective date of the filing. Any deficiencies or discrepancies in the filing will delay final approval. In case of disapproval, the company will be notified by the division.

35.7(5) Any insured or established organization with one or more insureds among its members may file a written request with the commissioner for a hearing on a proposed form filing. A request for hearing must be filed within 20 days of receipt of the form filing by the commissioner.

35.7(6) The commissioner of insurance will hold the hearing within 20 days after receipt of the written demand for a hearing and will give not less than 10 days' written notice of the time and place of the hearing to the person or association filing the demand, to the filing insurer or organization, and to any other person requesting notice. The commissioner of insurance may suspend or postpone the effective date of the proposed filing pending such hearing.

191—35.8(509) Electronic delivery of accident and health group insurance certificates.

35.8(1) *Purpose.* The purpose of this rule is to authorize the electronic delivery of accident and health group insurance certificates in an efficient manner by insurers and group policyholders, while guaranteeing that individual plan members still receive the important information contained in such group insurance certificates, as required by Iowa Code section 509.3(2), and as allowed by the uniform electronic transactions Act, Iowa Code chapter 554D.

35.8(2) *Scope.* This rule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapters 508 and 515.

35.8(3) *Electronic delivery—insurance companies.* The insurer will be deemed to comply with the requirements of Iowa Code section 509.3(2) if the group insurance certificate is delivered to the group policyholder electronically and if:

a. The insurer takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by group policyholders, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each group policyholder is provided notice, through electronic means or in writing, apprising the group policyholder of the fact that the certificate will be furnished electronically, of the significance of the certificate and the group policyholder's obligations under this rule, and of the group policyholder's right to request and receive a paper copy of the document for each participant.

d. Upon request of any group policyholder, the insurer furnishes paper copies of the group insurance certificate that was delivered to the group policyholder electronically, so that the group policyholder may provide them to participants that have requested paper copies.

35.8(4) *Electronic delivery—group policyholders.* The group policyholder will be deemed to comply with the requirements of Iowa Code section 509.3(2) if the group insurance certificate is delivered to the individual plan member electronically and if:

a. The group policyholder takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by participants, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each participant is provided notice, through electronic means or in writing, apprising the participant of the fact that the certificate will be furnished electronically, of the significance of the certificate, and of the participant's right to request and receive, free of charge, a paper copy of the document.

d. Upon request of any participant, the group policyholder furnishes, free of charge, a paper copy of the group insurance certificate that was delivered to the participant electronically.

This rule is intended to implement Iowa Code chapter 509.

191—35.9 to **35.19** Reserved.

191—35.20(509A) Life and health self-funded plans.

35.20(1) Scope. This rule shall apply to life and health self-funded plans for political subdivisions of the state, school corporations, and all other public bodies of the state. This rule shall not apply to life and health self-funded plans for the state of Iowa.

35.20(2) Iowa Code chapter 28E agreements—certificate of registration. Public entities seeking to pool risk through a joint exercise of power under Iowa Code chapter 28E shall apply for and obtain a certificate of registration from the commissioner. This subrule shall not apply to single-employer public entities with self-insured plans.

a. An application for a certificate of registration shall contain the following:

(1) A copy of the proposed agreement entered into pursuant to Iowa Code chapter 28E, to be executed by all plan participants;

(2) A copy of the articles of incorporation, bylaws, agreements, or other documents or instruments describing the rights and obligations of employers, employees and beneficiaries;

(3) A copy of all contracts with insurance companies, consultants and third-party administrators;

(4) A business plan, including a copy of all contracts or other instruments which the 28E agreement proposes to make with or sell to its members, a copy of its plan description and the printed matter to be used in the solicitation of members; and

(5) A current list of all participating public entities.

b. Iowa Code chapter 28E agreements shall contain the following provisions:

(1) If the plan is in a deficit position, a participant cannot terminate from the plan without the prior written consent of the commissioner;

(2) If a participant in the plan terminates, the terminating participant shall be assessed its proportionate share of the plan's deficit, if any;

(3) Deficit assessments shall be mandatory for all plan participants within a time frame acceptable to the commissioner;

(4) Plan participants have no individual interest in the accumulated surplus of a plan; and

(5) Upon termination of the plan, surplus remaining after the payment of all liabilities shall be distributed proportionately to plan participants that were active members of the plan on the termination date.

c. Reporting requirements. In addition to the requirements of subrule 35.20(3), all public entities pooling risk shall submit:

(1) Quarterly financial statement. A plan shall file with the commissioner of insurance within 60 days of the end of each quarter a report which has been verified by at least two of its principal officers and which covers the preceding calendar quarter. The report shall be on a form prescribed by the commissioner. The commissioner of insurance may request additional reports and information from a plan as often as is deemed necessary.

(2) Amendments. A plan shall submit copies of any proposed amendment to the documents submitted in accordance with subrule 35.20(2), paragraph *"a,"* 30 days in advance of the amendment's proposed effective date.

(3) Other documents. A plan shall submit any other documents deemed necessary by the commissioner.

35.20(3) Minimum plan standards for both pooled and single-employer public entities. Self-funded life plans subject to this rule shall meet the requirements of Iowa Code sections 509.1, 509.2, 509.4, and 509.15 and rules thereunder. Self-funded health plans subject to this rule shall meet the requirements of Iowa Code sections 509.1 and 509.3 and rules thereunder. In order to ensure that a self-funded life or health plan is able to cover all reasonably anticipated expenses and to avoid liability for the public body, a self-funded life or health plan shall provide that:

a. An annual report showing the starting and ending balance of the fund, deposits of monthly accrual rates and other assets of the fund, and the amount and nature of all disbursements from the fund shall be prepared and submitted to the governing body of the public body. An annual report shall be made to show a separate accounting to reflect all required reserves.

b. Monthly accrual rates shall be established at a satisfactory level to provide funds to cover all claims, reserves, and expenses to operate the plan. Accrual rates shall be reevaluated annually. Accrual rates shall be funded solely through public body contributions or through a combination of employer and employee contributions.

c. A plan fund shall be established exclusively for the deposit of monthly accrual rates and other assets pertaining to the plan. After a self-funded life or health plan is established and as long as any claims may be made against the plan fund, all contributions shall be deposited as collected in the plan fund. The plan fund shall be disbursed only for plan expenses.

d. The following reserves shall be established in the plan fund:

(1) A reserve for claims that have been incurred by participants under the plan, but have not yet been presented for payment. The appropriate amount of this reserve shall be on an actuarially sound basis as determined by an independent actuary, an insurance company, or a nonprofit health service corporation authorized pursuant to Iowa Code chapter 514.

(2) A claims fluctuation reserve for setting aside funds that become available during a month when claims are less than projected for that month. Funds shall be maintained and available for a month in which claims exceed those projected for that month. For public entities that require a certificate of registration under subrule 35.20(2), the claims fluctuation reserve shall equal or exceed a minimum of two months of paid claims.

e. The public body shall obtain a fidelity bond as a guaranty of faithful operation of the self-funded plan by the public body, its officers, agents, and employees.

f. Disbursements from the plan fund shall be made only for the following specified plan expenses:

(1) Payment of claims.

(2) Cost of aggregate excess loss coverage.

(3) Cost of specific excess loss coverage.

(4) Bonding expenses.

(5) Payment of service fees applicable to plan design, payment of claims, materials explaining plan benefits, actuarial assistance, legal assistance, and accounting assistance.

(6) Other expenses directly related to the operation of the plan.

g. Aggregate excess loss coverage shall be obtained which will limit a public body's total claim liability for each year to not more than 125 percent of the level of claims liability as projected by an independent actuary or insurance company. A public body shall fund this potential additional liability of 25 percent either by allocating necessary funds from the operating fund of the general fund or by setting up an additional reserve in the operating fund. Specific excess loss coverage may also be obtained if a public body wishes to limit its total annual liability on claims for any one claimant.

h. The commissioner may retain an independent actuary, at the commissioner's discretion, to review the adequacy of a plan's reserves. The cost of such review shall be paid by the plan. Examples that illustrate when the commissioner may retain an independent actuary include, but are not limited to, negative trends in the plan's financial statements, an increase in consumer complaints about the plan's failing to timely pay claims and material changes to the plan's operations.

35.20(4) Plan shortfalls. If the resources of any self-funded plan subject to this rule are not adequate to fully cover all claims under that plan, then the public body sponsoring that plan shall make up the shortfall from other resources.

35.20(5) Confidentiality. Information held by the plan administrator of a self-funded plan shall be kept confidential. An employee or agent of the plan administrator shall not use or disclose any information to any person, except to the extent necessary to administer claims or as otherwise authorized by law.

35.20(6) A health self-funded plan subject to this rule shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of a self-funded plan's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the self-funded plan or a person contracting with the self-funded plan.

The self-funded plan shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the self-funded plan that, in the opinion of the provider, jeopardizes patient health or welfare.

35.20(7) Benefits shall be made available by the health self-funded plan for inpatient and outpatient emergency services. Since self-funded plans may not contract with every emergency care provider in an area, self-funded plans shall make every effort to inform members of participating providers.

The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish the services that are needed to evaluate or stabilize an emergency medical condition.

The term "emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy;
2. Serious impairment to bodily function; or
3. Serious dysfunction of any bodily organ or part.

Reimbursement to a provider of "emergency services" shall not be denied by any health maintenance organization without that organization's review of the patient's medical history, presenting symptoms, and admitting or initial diagnosis as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that a noncontracted provider performed services. If reimbursement for emergency services is denied, the enrollee may file a complaint with the self-funded plan. Upon denial of reimbursement for emergency services, the self-funded plan shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

35.20(8) A health self-funded plan subject to this rule shall allow a female member direct access to obstetrical or gynecological services from network and participating providers. The plan shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

This rule is intended to implement Iowa Code chapter 509A and 2003 Iowa Acts, chapter 83.

191—35.21(509) Review of certificates issued under group policies.

35.21(1) *Nondiscretionary groups.* A certificate of coverage delivered in this state under a group life or accident and health insurance policy issued to a group substantially as described in Iowa Code section 509.1, subsections (1) to (7), shall not be reviewed by the commissioner if the policy is issued outside of this state.

35.21(2) *Discretionary groups.* A certificate of coverage delivered in this state under a group life or accident and health insurance policy issued to a group not substantially as described in Iowa Code section 509.1, subsections (1) to (7), shall not be reviewed by the commissioner if the policy is issued outside of this state and if the policy is issued or offered in a state which has reviewed and approved the policy under a statute substantially similar to Iowa Code section 509.1(8).

These rules are intended to implement Iowa Code sections 509.1, 509.6, and 509A.14.

LARGE GROUP HEALTH INSURANCE COVERAGE

191—35.22(509) Purpose. This division of Chapter 35 implements the requirements of Pub.L. 104-191, the Health Insurance Portability and Accountability Act of 1996 and Iowa Code section 509.3 for large group health insurance coverage.

191—35.23(509) Definitions.

"Affiliation period" means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

"Beneficiary" has the meaning given the term under Section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA), which states, "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit" under the plan.

"Bona fide association" means, with respect to group health insurance coverage offered in Iowa, an association that meets the following conditions:

1. Has been actively in existence for at least five years.
2. Has been formed and maintained in good faith for purposes other than obtaining insurance.
3. Does not condition membership in the association on any health status-related factor relating to an individual including an employee of an employer or a dependent of any employee.
4. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member.
5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

"Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

"COBRA" means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Commissioner" means the commissioner of insurance.

"Continuation coverage" means coverage under a COBRA continuation provision or a similar state program. Coverage provided by a plan that is subject to a COBRA continuation provision or similar state program, but that does not satisfy all the requirements of that provision or program, will be deemed to be continuation coverage if it allows an individual to elect to continue coverage for a period of at least 18 months. Continuation coverage does not include coverage under a conversion policy required to be offered to an individual upon exhaustion of continuation coverage, nor does it include continuation coverage under the Federal Employees Health Benefits Program.

"Creditable coverage" means health benefits or coverage provided to an individual under any of the following:

1. A group health plan.
2. Health insurance coverage.
3. Part A or Part B Medicare pursuant to Title XVIII of the federal Social Security Act.
4. Medicaid pursuant to Title XIX of the federal Social Security Act, other than coverage consisting solely of benefits under Section 1928 of that Act.
5. 10 U.S.C. ch. 55.
6. A health or medical care program provided through the Indian Health Service or a tribal organization.
7. A state health benefits risk pool.
8. A health plan offered under 5 U.S.C. ch. 89.
9. A public health plan as defined under federal regulations.
10. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).
11. An organized delivery system licensed by the director of public health.
12. A short-term limited durational policy.

"Director" means the director of public health appointed pursuant to Iowa Code section 135.2.

"Division" means the division of insurance.

"Eligible employee" means an individual who is eligible to enroll in group health insurance coverage offered to a group health plan maintained by an employer, in accordance with the terms of the group health plan.

"Employee" means any individual employed by an employer.

"Enrollment date" means the first day of coverage or, if there is a waiting period, the first day of the waiting period.